		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006353

Facility Name: Apostolic Christian Skylines

Address: 7023 NE Skyline Drive (Number) Peoria (City) 61614 (Zip Code)

County: Peoria

Telephone Number: 309-691-8092 **Fax #** 309-683-2505

IDPA ID Number: 370716056002

Date of Initial License for Current Owners: 08/12/1966

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dave Blunier **Telephone Number:** 309-691-8091

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Roger D. Herman
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,110	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	43	Intermediate (ICF)	43	15,695	3
4	0	Intermediate/DD	0	0	4
5	29	Sheltered Care (SC)	29	10,585	5
6	0	ICF/DD 16 or Less	0	0	6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	608	3,306	886	4,800	8
9	SNF/PED	0	0	0		9
10	ICF	3,231	12,159	0	15,390	10
11	ICF/DD	0	0	0		11
12	SC	365	6,544	0	6,909	12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	4,204	22,009	886	27,099	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.33%

D. How many bed-hold days during this year were paid by Public Aid?
56 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals, housekeeping, laundry, grounds maintenance, outpatient therapy,

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/12/1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 886

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2003 Fiscal Year: 2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	191,188	13,966	2,106	207,260	(7,713)	199,547	(14,024)	185,523			1
2	Food Purchase		155,159		155,159	(5,586)	149,573	(10,155)	139,418			2
3	Housekeeping	107,536	18,007		125,543		125,543		125,543			3
4	Laundry	43,782	7,944		51,726		51,726	(1,013)	50,713			4
5	Heat and Other Utilities			97,268	97,268		97,268	(20,460)	76,808			5
6	Maintenance	68,019	66,349	15,940	150,308		150,308	(43,900)	106,408			6
7	Other (specify):* Security, Disposal			3,944	3,944		3,944	(394)	3,550			7
8	**TOTAL General Services**	410,525	261,425	119,258	791,208	(13,299)	777,909	(89,946)	687,963			8
	B. Health Care and Programs											
9	Medical Director			431	431		431		431			9
10	Nursing and Medical Records	1,543,438	82,057	720	1,626,215	3,705	1,629,920		1,629,920			10
10a	Therapy			55,135	55,135		55,135		55,135			10a
11	Activities	106,076	3,291	1,340	110,707		110,707		110,707			11
12	Social Services	66,493		1,780	68,273		68,273		68,273			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,716,007	85,348	59,406	1,860,761	3,705	1,864,466		1,864,466			16
	C. General Administration											
17	Administrative	64,168			64,168		64,168		64,168			17
18	Directors Fees											18
19	Professional Services			38,732	38,732	(7,430)	31,302		31,302			19
20	Dues, Fees, Subscriptions & Promotions			5,722	5,722		5,722		5,722			20
21	Clerical & General Office Expenses	93,872	30,177	13,964	138,013	3,725	141,738	(9,326)	132,412			21
22	Employee Benefits & Payroll Taxes			555,628	555,628	17,001	572,629	(16,669)	555,960			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,480	16,480	(3,702)	12,778		12,778			24
25	Other Admin. Staff Transportation		439		439		439		439			25
26	Insurance-Prop.Liab.Malpractice			108,599	108,599		108,599	(10,860)	97,739			26
27	Other (specify):*											27
28	**TOTAL General Administration**	158,040	30,616	739,125	927,781	9,594	937,375	(36,855)	900,520			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,284,572	377,389	917,789	3,579,750		3,579,750	(126,801)	3,452,949			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Skylines #0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			181,892	181,892		181,892	(38,472)	143,420			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			940	940		940	(940)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			182,832	182,832		182,832	(39,412)	143,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			170,257	170,257		170,257		170,257			39
40	Barber and Beauty Shops			19,771	19,771		19,771		19,771			40
41	Coffee and Gift Shops			6,809	6,809		6,809		6,809			41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):* **Non-Care**	60,178		69,291	129,469		129,469	(129,469)				43
44	**TOTAL Special Cost Centers**	60,178		297,336	357,514		357,514	(129,469)	228,045			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,344,750	377,389	1,397,957	4,120,096		4,120,096	(295,682)	3,824,414			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,179)	1,2		4
5	Telephone, TV & Radio in Resident Rooms	(10,319)	21,5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,013)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	21		13
14	Non-Care Related Interest	(940)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(259,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (295,682)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (295,682)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Apostolic Christian Skylines

ID# 0006353

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Non-care related expenses	$ (129,469)	43	1
2	Non-care related depreciation	(38,472)	30	2
3	Non-care related maintenance supplies	(43,900)	6	3
4	Non-care related heat and other utilities	(19,454)	5	4
5	Non-care security and disposal	(394)	7	5
6	Non-care insurance	(10,860)	26	6
7	Non-care benefits and payroll taxes	(16,669)	22	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(259,218)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(14,024)	0	0	0	0	0	0	0	0	0	0	(14,024)	1
2	Food Purchase	(10,155)	0	0	0	0	0	0	0	0	0	0	(10,155)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,013)	0	0	0	0	0	0	0	0	0	0	(1,013)	4
5	Heat and Other Utilities	(20,460)	0	0	0	0	0	0	0	0	0	0	(20,460)	5
6	Maintenance	(43,900)	0	0	0	0	0	0	0	0	0	0	(43,900)	6
7	Other (specify):*	(394)	0	0	0	0	0	0	0	0	0	0	(394)	7
8	**TOTAL General Services**	(89,946)	0	0	0	0	0	0	0	0	0	0	(89,946)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(9,326)	0	0	0	0	0	0	0	0	0	0	(9,326)	21
22	Employee Benefits & Payroll Taxes	(16,669)	0	0	0	0	0	0	0	0	0	0	(16,669)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(10,860)	0	0	0	0	0	0	0	0	0	0	(10,860)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(36,855)	0	0	0	0	0	0	0	0	0	0	(36,855)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(126,801)	0	0	0	0	0	0	0	0	0	0	(126,801)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(38,472)	0	0	0	0	0	0	0	0	0	0	(38,472)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(940)	0	0	0	0	0	0	0	0	0	0	(940)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,412)	0	0	0	0	0	0	0	0	0	0	(39,412)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(129,469)	0	0	0	0	0	0	0	0	0	0	(129,469)	43
44	**TOTAL Special Cost Centers**	(129,469)	0	0	0	0	0	0	0	0	0	0	(129,469)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(295,682)	0	0	0	0	0	0	0	0	0	0	(295,682)	45

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Apostolic Christian Skylines **#** 0006353 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Skyline[illegible] COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,100 B. General Construction Type: Exterior Brick Frame Steel/Masonary Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Storage and Maintenacne Facility - 4,650 Square Feet
Apartment Complex (assisted living) - 18,850 Square Feet, 12 assisted living units and 5 independent living units
Duplexes - 1,150 Square Feet per unit, 16 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	200,000	1964	$ 743	1
2					2
3	TOTALS	200,000		$ 743	3

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	32		1966	1965	$ 348,310	$ 6,966	50	$ 6,966	$ (0)	$ 264,716	4
5	21		1971	1971	396,963	7,939	50	7,939		261,996	5
6	16		1985	1985	750,000	15,000	50	15,000		285,000	6
7	3		1989	1988	205,070	4,101	50	4,101		61,521	7
8			1995	1995	870,388	17,408	50	17,408		156,670	8
	Improvement Type**										
9	17 Bed Room Addition Acquired in 1996			1996	793,538	15,871	50	15,871		126,966	9
10	Sheltered Care Remodeling			1974	6,594	157	42	157		4,710	10
11	Fire Prevention System			1977	23,804	541	44	541		14,607	11
12	Dining Room Addition			1978	38,922	1,024	38	1,024		26,631	12
13	Fire Prevention System			1979	35,330	955	37	955		23,872	13
14	Window Replacement			1981	23,820	681	35	681		15,653	14
15	Kitchen Remodeling			1982	21,631	636	34	636		13,997	15
16	Energy Conservation, Cabinets, Water Heater, Emerg. Power			1983	8,413	255	33	255		5,354	16
17	Sheltered Care Remodeling			1984	7,742	242	32	242		4,839	17
18	Cabinets			1986	1,618	54	30	54		971	18
19	Air Conditioning			1987	6,427	222	29	222		3,768	19
20	Physical Therapy Room			1989	11,503	426	27	426		6,391	20
21	Office Addition			1991	50,297	2,012	25	2,012		26,154	21
22	New Roof			1993	14,210	618	23	618		6,796	22
23	Froom Remodeling			1994	5,154	234	22	234		2,343	23
24	Front Entrance Canopy, Front Office, Ceiling Back Hall			1996	62,294	3,115	20	3,115		24,918	24
25	Gutters and Downspout and Facia, Remodel 1971			1996	89,096	3,564	25	3,564		28,511	25
26	Fence, Front Soffit and Facia, Auto Front Door			1997	28,036	1,168	24	1,168		8,177	26
27	New Floor Coverings, Light Fixtures, Paint, Wallpaper			1998	88,061	3,829	23	3,829		22,972	27
28	Door and Fire Alarms			2000	4,978	151	33	151		603	28
29	New Floor Coverings, Light Fixtures, Paint, Wallpaper			2000	110,832	3,359	33	3,359		13,434	29
30	New Floor Converings, Bookcases Paint, Wallpaper			2001	42,939	1,342	32	1,342		4,026	30
31	New Lobby Window			2001	3,577	238	15	238		715	31
32	New Air Conditioner Units in 1989 Addition			2001	2,178	57	38	57		172	32
33	Blacktop for Parking Lot			2001	13,967	436	32	436		1,309	33
34	Balcony Repair			2001	10,888	726	15	726		2,178	34
35	Insulation			2001	9,970	312	32	312		935	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Lawn Sprinkler System	2001	$ 9,650	$ 302	32	$ 302	$	$ 905	37
38	Door Locks	2002	691	22	31	22		45	38
39	New Floor, Paint, Wallpaper, Tub in Bathroom in 1966 Build	2002	14,570	1,041	14	1,041		2,081	39
40	New Floor, Paint, Wallpaper, and Trim in 1966 Build	2002	9,786	699	14	699		1,398	40
41	Balcony Repair	2002	7,403	528	14	528		1,058	41
42	Carpet for Dining Room	2002	5,446	124	44	124		248	42
43	New Hot Water Heater	2002	4,197	113	37	113		227	43
44	Lawn Sprinkler System	2002	8,888	287	31	287		573	44
45	Sewer System	2002	6,400	206	31	206		413	45
46	Condenser for Main Entrance	2003	1,700	131	13	131		131	46
47	Sewer Upgrade	2003	6,400	213	30	213		213	47
48	New Contertops in 1996 addition	2003	6,594	153	43	153		153	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,168,275	$ 97,458		$ 97,458	$ (0)	$ 1,428,350	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 716,736	$ 35,837	$ 35,837	$	20	$ 259,555	71
72	Current Year Purchases	71,571	3,578	3,578		20	3,578	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 788,307	$ 39,415	$ 39,415	$		$ 263,133	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenace	1979 John Deere	1979	$ 4,400	$	$	$	20	$ 4,400	76
77	Resident Transportation	1999 Ford Bus	1999	58,988	5,899	5,899		10	29,495	77
78	Maintenace	2002 John Deere 737	2002	6,475	648	648		10	1,296	78
79										79
80	TOTALS			$ 69,863	$ 6,547	$ 6,547	$		$ 35,191	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,027,188	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,420	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,420	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,726,674	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1978 & 1985Apartment Complex	$ 1,271,924	$ 25,438	$ 560,080	86
87	Improvements	146,997	8,141	82,506	87
88	Non-Care Equipment	55,860	2,793	22,163	88
89	Non-Care Vehicles	28,450	2,100	16,560	89
90					90
91	TOTALS	$ 1,503,231	$ 38,472	$ 681,309	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	$	39	$ 2,165	$	39	$ 2,165	1
2	Licensed Speech and Language Development Therapist	10a	hrs		22	1,202		22	1,202	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		93	5,419		93	5,419	4
5	Physician Care		visits							5
6	Dental Care	10	visits			1,847			1,847	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				163,582		163,582	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	155	$ 10,633	$ 163,582	155	$ 174,215	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 44,503	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	362,381		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	573,809		5
6	Prepaid Insurance	19,069		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 999,762	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,066,890		12
13	Land	113,189		13
14	Buildings, at Historical Cost	5,587,194		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	942,479		16
17	Accumulated Depreciation (book methods)	(2,402,142)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	84,083		21
22	Other Long-Term Assets (sp Wellspring Licen.	6,263		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,397,956	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,397,718	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 60,966	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,173		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee benefits payable	60,240		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 189,379	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Contingent payable	84,083		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 84,083	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 273,462	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,124,256	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,397,718	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,959,982	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,959,982	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	164,274	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 164,274	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,124,256	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,607,369	1
2	Discounts and Allowances for all Levels	(215,562)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,391,807	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	77,456	6
7	Oxygen	4,730	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 82,186	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,286	12
13	Barber and Beauty Care	18,136	13
14	Non-Patient Meals	28,612	14
15	Telephone, Television and Radio	9,313	15
16	Rental of Facility Space		16
17	Sale of Drugs	162,832	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,704	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,013	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 229,896	23
	D. Non-Operating Revenue		
24	Contributions	478,141	24
25	Interest and Other Investment Income***	95,952	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 574,093	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Non-care Revenues	6,388	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,388	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,284,370	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	791,208	31
32	Health Care	1,860,761	32
33	General Administration	927,781	33
	B. Capital Expense		
34	Ownership	182,832	34
	C. Ancillary Expense		
35	Special Cost Centers	326,306	35
36	Provider Participation Fee	31,208	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,120,096	40
41	**Income before Income Taxes (line 30 minus line 40)****	164,274	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 164,274	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,870	2,070	$ 54,491	$ 26.32	1
2	Assistant Director of Nursing	1,919	2,070	48,778	23.56	2
3	Registered Nurses	15,853	16,646	327,005	19.64	3
4	Licensed Practical Nurses	15,021	15,900	267,358	16.81	4
5	Nurse Aides & Orderlies	70,820	74,739	823,355	11.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,619	3,812	40,671	10.67	9
10	Activity Assistants	7,098	7,637	65,405	8.56	10
11	Social Service Workers	3,882	4,050	66,493	16.42	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,027	22,847	11.27	13
14	Head Cook	2,643	2,907	25,872	8.90	14
15	Cook Helpers/Assistants	13,008	13,752	142,469	10.36	15
16	Dishwashers					16
17	Maintenance Workers	4,348	4,846	68,019	14.04	17
18	Housekeepers	9,520	10,122	107,536	10.62	18
19	Laundry	5,059	5,383	43,782	8.13	19
20	Administrator	1,905	2,070	64,168	31.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,877	2,070	42,491	20.53	23
24	Clerical	5,610	5,917	51,381	8.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,974	2,054	22,451	10.93	31
32	Other Health Care(specify)					32
33	Other(specify) non-care wages	4,457	4,457	60,178	13.50	33
34	TOTAL (lines 1 - 33)	172,447	182,529	$ 2,344,750 *	$ 12.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	77	$ 2,106	1	35
36	Medical Director	6	431	9	36
37	Medical Records Consultant	16	720	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	76	1,525	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	1,340	11	44
45	Social Service Consultant	31	1,780	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	240	$ 7,902		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roger D. Herman	Administrator	0	$ 64,168
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,168

B. Administrative - Other

Description	Amount
None	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Westervelt, Johnson, etc.	Legal	$ 4,767
Michael Best & Friederich	Legal	11,238
Wellspring	Innovative Solutions	7,319
Wellspring Amortization	Innovative Solutions	6,263
Architectural Design	Architect	885
Goernz & Assoc.	Accountant	830
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 31,302

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,568
Unemployment Compensation Insurance	9,253
FICA Taxes	174,038
Employee Health Insurance	238,757
Employee Meals	13,299
Illinois Municipal Retirement Fund (IMRF)*	
401k retirement plan	62,174
Employee physicals	4,324
Misc. employee incentives	22,257
Non-care benefits	(16,669)
TOTAL (agree to Schedule V, line 22, col.8)	$ 555,001

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	0
Health Care Worker Background Check	313
(Indicate # of checks performed 20)	
Misc. Subscriptions	2,876
Organization Membership Dues	2,533
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,722

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,537
In-State Travel	4,066
Seminar Expense	7,175
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,778

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN, AAHSA**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,773** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **31,208**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,299** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,433**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes - those that are care related**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Explanation of Reclassifications Pg. 3 column 5

1 Meals served to employees at a discount -
$13,299 was added to employee benefits
$7,713 was subtracted from dietary
$5,586 was subtracted from food purchases

2 Items were posted as professional fees which should not have been.
$3,705 was added to nursing costs
$3,725 was added to office costs
$7,430 was subtracted from professional fees

3 Items in Seminars should have been listed as employee benefits
$3,702 was deducted from seminars
$3,702 was added to employee benefits

Explanation of other lines on Schedule V Pg. 3

7 Line seven includes the following expenses
$3,154 for disposal services
$790.00 for security services

43 Line 43 includes expenditures which are not related to the operation of the licensed areas of the facility. These are expenditures for our independent living areas. Includes wages and benefits of personell performing duties outside of the licensed area. This line also includes expenditures which are not allowable for the cost report.

Listing of Board of Directors - 2003

Name	***Service Provided***
Norbert Schneider - President	No services performed
David Ginzel - Vice President	No services performed
Richard Hermann - Secretary	No services performed
Russell Rumbold - Treasurer	Goernz & Assoc. - Filing tax forms
Max Hoerr	No services performed
Bob Miller	No services performed
Larry Herman	No services performed
Dan Waibel	No services performed
Duane Elsasser	No services performed
Earl Grimm	No services performed
Marvin Knobloch	No services performed

Apostolic Christian Skylines
2003 Employee Seminar Expense

Employee	*Title*	*Seminar*	*Dates*	*Place*	*Sponsor*	*Cost*	*Travel*
Feucht, Matt	Dir. Of Resident	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$115.00	$0.00
Meister, Kristin	Medical Records	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Herman, Roger	Administrator	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Ehnle, Gwenn	Activity Director	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Davis, Renee	Social Services	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Cooley, Jackie	RN	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Knobloch, Loris	Dir. Environmental	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Spencer, Trudy	DON	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Blunier, Dave	Business Manager	Finding Practical Solutions to	February 13, 2003	Peoria	LSN	$0.00	$0.00
Baer, Rachel	Bookkeeper	Medicare Coverage 101	February 19, 2003	Springfield	IL Council on LTC	$150.00	$57.67
Blunier, Dave	Business Manager	IL Senior Living CFO Workshop	March 6, 2003	Arlington	Ziegler	$100.00	$76.59
Spencer, Trudy	DON	InfoForum	March 20, 2003	Peoria	LSN	$0.00	$5.00
Blunier, Dave	Business Manager	InfoForum	March 20, 2003	Peoria	LSN	$0.00	$5.00
Herman, Roger	Administrator	InfoForum	March 20, 2003	Peoria	LSN	$0.00	$5.00
Knobloch, Loris	Dir. Environmental	InfoForum	March 20, 2003	Peoria	LSN	$0.00	$5.00
Blunier, Dave	Business Manager	Unfounded Unemployment	January 23, 2003	Peoria	Employer's Association	$119.00	$0.00
Cooley, Jackie	RN	CPR Review	January 20, 2003	Peoria	American Red Cross	$300.00	$0.00
Wilson, Virginia	LPN	CPR Review	January 20, 2003	Peoria	American Red Cross	$0.00	$0.00
Ringenberg, Nan	LPN	CPR Review	January 20, 2003	Peoria	American Red Cross	$0.00	$0.00
Tatum, Linda	RN	CPR Review	January 20, 2003	Peoria	American Red Cross	$0.00	$0.00
Reith, Irma	RN	CPR Review	January 20, 2003	Peoria	American Red Cross	$0.00	$0.00
Price, Pat	LPN	CPR Review	January 20, 2003	Peoria	American Red Cross	$0.00	$0.00
Lister, Joy	RN	CPR Review	January 20, 2003	Peoria	American Red Cross	$0.00	$0.00
Lindbom, Deb	LPN	CPR Review	January 20, 2003	Peoria	American Red Cross	$0.00	$0.00
Streitmatter, Cheri	LPN	CPR Review	January 27, 2003	Peoria	American Red Cross	$0.00	$0.00
Vyverberg, Mari	ADON	CPR Review	January 27, 2003	Peoria	American Red Cross	$0.00	$0.00
Spencer, Trudy	DON	CPR Review	January 27, 2003	Peoria	American Red Cross	$0.00	$0.00
Hurst, Tracey	LPN	CPR Review	January 27, 2003	Peoria	American Red Cross	$0.00	$0.00
Krans, Susan	RN	CPR Review	January 27, 2003	Peoria	American Red Cross	$0.00	$0.00
Streitmatter, Naomi	RN	CPR Review	January 27, 2003	Peoria	American Red Cross	$0.00	$0.00
Burk, LeeAnn	LPN	CPR Review	January 27, 2003	Peoria	American Red Cross	$0.00	$0.00
Blunier, Dave	Business Manager	LSN Conference	April 9, 10, 11, 2003	Chicago	LSN	$0.00	$25.50
Cooley, Jackie	RN	LSN Conference	April 9, 10, 11, 2003	Chicago	LSN	$0.00	$0.00
Knobloch, Loris	Dir. Environmental	LSN Conference	April 9, 10, 11, 2003	Chicago	LSN	$0.00	$0.00
Herman, Roger	Administrator	LSN Conference	April 9, 10, 11, 2003	Chicago	LSN	$1,580.00	$2,755.11
Feucht, Matt	Dir. Of Resident	Deliver Exceptional Customer	April 29, 2003	Peoria	Fred Pryor Seminars	$99.00	$0.00
Hammond, Dawn	CNA	Restorative Aid Training	August 19, 2003	Peoria	Professional Therapy	$32.00	$0.00
Hammond, Ian	CNA	Restorative Aid Training	August 19, 2003	Peoria	Professional Therapy	$32.00	$0.00
Bowen, Ashley	CNA	Restorative Aid Training	August 19, 2003	Peoria	Professional Therapy	$32.00	$0.00
Masters, Cathy	CNA	Restorative Aid Training	August 19, 2003	Peoria	Professional Therapy	$32.00	$0.00
Richardson, Holly	CNA	Restorative Aid Training	August 19, 2003	Peoria	Professional Therapy	$32.00	$0.00
Vaughn, Angela	CNA	Restorative Aid Training	August 19, 2003	Peoria	Professional Therapy	$32.00	$0.00
Durham, Callie	CNA	Restorative Aid Training	August 19, 2003	Peoria	Professional Therapy	$32.00	$0.00
Murdoch, Ronda	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Taylor, Shelana	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Beck, JoLinn	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Mays, Latoya	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Jackson, Lynne	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Parker, Tiffany	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Snell, Deb	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Ellis, Alaina	CNA	Restorative Aid Training	August 26, 2003	Peoria	Professional Therapy	$32.00	$0.00
Johnson, Vanessa	Dietary Assistant	Food Service Training Course	October 7,9,14,16,21,23,	Peoria	Peoria City/Health Dept	$50.00	$0.00
Cowan, Sabrina	Dietary Assistant	Food Service Training Course	October 7,9,14,16,21,23,	Peoria	Peoria City/Health Dept	$50.00	$0.00
Ehnle, Gwenn	Activity Director	Activity Based Alzheimer's Care	October 23, 2003	Peoria	Alzheimer's Association	$75.00	$0.00
Tanner, Imogene	Dietary Manager	Dietary Management Class	May 25, 2003	Peoria	Auburn University Distance	$643.00	$0.00
Post, Wanda	Activity Assistant	Activity Based Alzheimer's Care	May 22, 2003	Quincy	Alzheimer's Association	$50.00	$134.69
Myers, Cindy	Activity Assistant	Activity Based Alzheimer's Care	May 22, 2003	Quincy	Alzheimer's Association	$50.00	$0.00
Wilson, Virginia	LPN	Wellspring Restorative Follow-up	July 29, 2003	Metamora	Wellspring	$0.00	$0.00
Ehnle, Gwenn	Activity Director	Wellspring Restorative Follow-up	July 29, 2003	Metamora	Wellspring	$0.00	$0.00
Lingenfelter, Phyllis	Activity Assistant	Wellspring Restorative Follow-up	July 29, 2003	Metamora	Wellspring	$0.00	$0.00
Mabberly, Rachel	CNA	Wellspring Restorative Follow-up	July 29, 2003	Metamora	Wellspring	$0.00	$0.00
Taylor, Shelana	CNA	Wellspring Restorative Follow-up	July 29, 2003	Metamora	Wellspring	$0.00	$0.00
Cooley, Jackie	RN	IL New Medicaid Reimbursement	August 4, 2003	Peoria	IL Health Care Association	$82.50	$6.00
Stoller, Peg	RN	IL New Medicaid Reimbursement	August 4, 2003	Peoria	IL Health Care Association	$82.50	$0.00
Feucht, Matt	Dir. Of Resident	Alzheimer's Education	April 30, 2003	Peoria	Alzheimer's Association	$55.00	$0.00
Davis, Renee	Social Services	Alzheimer's Education	April 30, 2003	Peoria	Alzheimer's Association	$55.00	$0.00
Adkinson, Nicole	CNA	Alzheimer's Education	April 30, 2003	Peoria	Alzheimer's Association	$55.00	$0.00
Christianson, Carol	CNA	Alzheimer's Education	April 30, 2003	Peoria	Alzheimer's Association	$55.00	$0.00
Hammond, Ian	CNA	Alzheimer's Education	April 30, 2003	Peoria	Alzheimer's Association	$55.00	$0.00
Burk, LeeAnn	LPN	Alzheimer's Education	April 30, 2003	Peoria	Alzheimer's Association	$55.00	$0.00
Knobloch, Loris	Dir. Environmental	New Life Safety Code	August 14, 2003	Peoria	LSN	$99.00	$0.00
Morton, Marge	RN	CPR Review	July 28, 2003	Peoria	American Red Cross	$30.00	$0.00
Tanner, Imogene	Dietary Manager	Real Food for Real People	April 24, 2003	Springfield	IL Dept. on Aging	$5.00	$82.04
Blunier, Dave	Business Manager	Employee and Labor Relations	July 22, 2003	Springfield	LSN	$95.00	$0.00
Cooley, Jackie	RN	Navigating Waters of MDS	May 20, 2003	Morton	Professional Therapy	$40.00	$0.00
Wilson, Virginia	LPN	Navigating Waters of MDS	May 21, 2003	Morton	Professional Therapy	$40.00	$0.00
Feucht, Matt	Dir. Of Resident	Private Pay Census Development	June 17 & 18, 2003	Lombard	LSN	$195.00	$175.42
Spencer, Trudy	DON	MDS for Reimbursement	June 25 & 26, 2003	Peoria	INHAA	$75.00	$0.00
Wilson, Virginia	LPN	IL Health Care Convention	September 15-17	Peoria	IHCA	$825.00	$5.00
Vyverberg, Mari	RN	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Meister, Kristin	Medical Records	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Spencer, Trudy	DON	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$10.00
Davis, Evelena	CNA	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Hammond, Dawn	CNA	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Hammond, Ian	CNA	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Taylor, Shelana	CNA	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$5.00
Beck, JoLinn	CNA	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Bowen, Ashley	CNA	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Krans, Susan	RN	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$9.62
Blunier, Dave	Business Manager	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$62.45
Tanner, Imogene	Dietary Manager	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$10.00
Knobloch, Loris	Dir. Environmental	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$10.00
Feucht, Matt	Dir. Of Resident	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$15.00
Lingenfelter, Phyllis	Activity Assistant	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Ehnle, Gwenn	Activity Director	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$0.00
Pierce, Marie	Activity Director	IL Health Care Convention	September 15-17	Peoria	IHCA	$0.00	$5.00
Herman, Roger	Administrator	InfoForum	December 16, 2003	Metamora	LSN	0.00	15.00
Spencer, Trudy	DON	InfoForum	December 16, 2003	Metamora	LSN	0.00	0.00
Feucht, Matt	Dir. Of Resident	InfoForum	December 16, 2003	Metamora	LSN	0.00	0.00
Davis, Renee	Social Services	InfoForum	December 16, 2003	Metamora	LSN	0.00	0.00
Blunier, Dave	Business Manager	Leadership in Safety	December 9, 2003	Springfield	LSN	50.00	0.00
Knobloch, Loris	Dir. Environmental	Leadership in Safety	December 9, 2003	Springfield	LSN	50.00	0.00
Blunier, Dave	Business Manager	Administrator Exam Review	August 27-28	Springfield	IHCA	550.00	226.00
Tatum, Linda	RN	Alzheimer's Conference	November 13, 2003	Rock Falls	Alzheimer's Association	50.00	0.00
Cook, Rebecca	CNA	Alzheimer's Conference	November 13, 2003	Rock Falls	Alzheimer's Association	50.00	0.00
Herman, Roger	Administrator	Wellspring Annual Meeting	November 13, 2003	Milwaukee	Wellspring	0.00	126.28
Herman, Roger	Administrator	Leadership Retreat	August 25-27	St. Charles	LSN	0.00	233.69
Herman, Roger	Administrator	AAHSA Annual Conference	October 26-29	Colorado	AAHSA	665.00	1,537.48
						$7,175.00	***$5,603.54***

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